Utah State Hospital Policies and Procedures Resource Catalog

This manual was prepared by
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Chapter 1

Mission of Groups

Groups at the Utah State Hospital are a key component of a therapeutic treatment approach for individuals with psychiatric illnesses. Groups provide individuals with the opportunity to interact by sharing or dealing with individual and common issues in a supportive environment. Group members learn and try new behaviors, coping techniques, or skills.

Chapter 2

Introduction to Manual

This group manual is a joint effort group coordinators from each unit in the hospital, discipline chiefs, and BYU clinical psychology department. As we worked together, an effort was made to address prominent issues and to creat a policy and procedure manual for group treatment offered at the Utah State Hospital (USH). Our goal was to create a manual that was relevant, easy to use, and compliant with national standards. Therefore some of the terminology may be new to hospital personnel because it incorporates terms used by the Association of Specialists in Group Work (ASGW).

For the manual to be effective and worthwhile it must provide reference, information, and guidance for doing groups. To increase its relevance we welcome suggestions on information, format and additional treatment ideas. If a USH employee has potential additions, revisions, or other suggestions please contact your unit group coordinator so that when the manual is revised those ideas can be considered.

The writers of this manual would like to refer those seeking additional information on group treatment to consider any of the following sources.

1. Unit group coordinator—if you do not know who this is ask your AD. This person has been selected to represent group work on your unit. They can be a great source of information. Their basic roles are as follows:

A. Consultant in group programming with SMT

- identify weaknesses with competency and problem solve to find solutions

- review programming

- share staff interests

- recommend patients to groups (including initial patient assignments)

- recommend new groups

B. Run Group Consult

· Weekly meeting (minimum of 2 hrs/month; e.g., 30 min/week)

· Planned material highlighting basic group skills

· Implementer of Relationships between members, members and leader

· Facilitator of Treatment Factors

- Creating a group structure conducive to a healthy system relationship

- Creating and maintaining bonding among all group members

- Bringing to the group an armamentarium of intervention possibilities

- Applying said interventions in a flexible, variable manner

· Maintainer of Time Boundaries and Continuity

- Ensure that group meeting occur at regular, schedules intervals

- Provide continuity between session by recalling previous discussions

- Periodic evaluation of goal setting

· Foster positive spirit

- Belief and hope for improvement

- Organizational, Personal, Unit

C. Accessing resources (not to CREATE resources, but to establish connections and methods to find them)

D. Attend semi-monthly Group Coordinator meetings to establish a hospital-wide network

E. Consult with the AD and/or Program Director to coordinate the daily unit program

2. Unit group consult—Each unit should or soon will be holding group consult meetings. These meetings vary in time and provide a time to process specific group issues, learn about group dynamics, and get feedback on individual group offerings.

3. Group resource catalog—In the appendix on this manual is the group resource catalog. This is an index of all the group materials at the hospital and other central locations. This information may help you locate references, handouts, or manuals for a particular type of group. It is also now available online at the hospital and in hard copy in the staff library located in the Heniger building. Your unit group

coordinator also has a copy of this resource catalog as well.

Chapter 3

History of Groups at Utah State Hospital

One goal of this group treatment manual is to reconnect us with our roots. Indeed, the Utah State Hospital has a longstanding tradition of excellence in the delivery of group treatment that extends nearly 50 years. This history is reflected by recent published descriptions (Fuhriman & Burlingame, 2000) on how hospital staff members were useful in developing instruments that could track the quality of group treatments. In a sense, USH was engaged in systematic quality assurance efforts in the 1950s long before they became popular or part of accreditation standards. What follows is a brief account of this contribution and how it affected the group treatment literature.

Unquestionably, USH patient treatment protocols in the new millenium reflect a dramatically different orientation than those that guided patient treatment in the 1950s and 1960s. However, two key components have remained constant over the past half-century: (a) careful medical management including pharmacotherapy and, (b) the regular participation of patients in effective group treatments. It was the importance placed on group treatment at USH that attracted William Faucett Hill to accept a position in 1956. At the time, Dr. Hill was one of the few psychologists in the country who had received systematic training on how to scientifically impact the quality of small groups. His mentor—Herbert Thelen (trained by Kurt Lewin)—was recognized as a leading international authority on how to use the entire group and not just individual members in invoking change. Students who trained with Dr. Hill (Morton Lieberman, Carl Whitaker & Dorothy Stock Whitaker) have made very significant contribution to our understanding of small group treatments. For those who might be unfamiliar with these individuals, they can be thought of as the "dream team" of the group treatment literature whose impact carry us into the new millenium. When this 'world class' intellectual heritage was coupled with a supportive central and unit administration, the USH had the necessary components to make a world class "splash" and indeed we did. What follows is a summary of a few of the milestones by decade.

1950-1970

An important feature of USH's impact on group treatment and the literature was the partnering with faculty members at Brigham Young University. One important product of this partnership was the creation of the Provo Papers. This quarterly journal summarized some of the research and program development that resulted from the partnership. For example, covered topics included how to: introduce pharmacotherapy, use group therapy as a primary treatment, reduce seclusion & restraint hours, use 'attendants' (the precursor to Psych. Techs.) as group leaders, develop nursing group programs, introduce OT & RT groups. While these were important contributions, unquestionable the most

important contribution to the group literature was the development of the Hill Interaction Matrix: HIM.

The HIM is a tool for tracking the quality of interaction between members participating in group treatment. The hospital not only began to observe and track patients groups with this measure, they also began to publish these observation first in the Provo Papers and later in nationally recognized professional journals. For instance, some hospital staff members (Castore, Hill & Lake, 1959) tackled the issue of how complex interactions between group members could be reliable rated while others (Martin & Hill, 1957) started to offer theories of how groups developed over time. The 1950s & 1960s were unquestionably the most productive time period for USH staff members. In a recent summary of the group literature, it was noted that the HIM produced 150 studies in its first 10 years of existence. This is an unparalleled phenomenon in the group treatment literature is a powerful tribute to what can happen when staff, unit and central administration work together to improve the quality of patient treatment.

1970-1990

Shortly after Dr. Hill left USH (mid 1960s) he founded one of the leading professional journals devoted to small group treatment: Small Group Research (originally named Small Group Behavior). During the 1970s & 1980s a steady flow of scientific studies using the HIM were published. Indeed, one can find dozens of HIM contributions to the group literature during this time frame. In the 1970s articles from the 'old' USH team still could be found, however, with Dr. Hill's departure the intense focus on group treatments at USH started to wan. This was truly unfortunate since USH staff had led the field of group treatment for a significant portion of time.

1990-2000

In the early 1990s there was a renewed focus on improving groups conducted by the nursing discipline. Training sessions on how to assess, plan, implement and evaluate groups were started by Alrae Snyder & Joyce Matsumo. Both of these USH staff members developed manuals for psycho-educational groups (e.g., Anger Management, Understanding My Diagnosis, etc.) that were used throughout the hospital and Alrae Snyder also developed a training manual to guide nursing staff in the basics of group process.

In the latter part of this decade, under the auspices of a grant from the State Academic Collaborative Committe the connection between USH and BYU was

renewed. Three BYU faculty members (Fuhriman, Barlow & Burlingame)—all of who had made nationally visible contributions to the small group literature—joined the hospital in a collaborative enterprise to both study and improve the quality of groups. This partnership resulted in changes within the hospital such as: (a) the appointment of a standing group competency committee made up of central, discipline & unit adminstrators who were charged with improving group programming and tracking the effect of such with both process and outcome measurement tools; (b) the appointment of unit Group Coordinators who were charged with improving group programming and, (c) the establishment of weekly unit Group Consult meetings which functions as an ongoing inservice to highlight basic group skills, engage in problem solving and address group programming concerns.

In addition to these internal changes, USH began a systematic program to calibrate its group programming with "state of the art" treatment models. Accordingly, nationally and internationally visible experts (Dr. K. Roy MacKenzie, M.D., Dr. William MacFarlane, M.D., Dr. William Spaulding, Ph.D.) provided 1 to 2 day workshops on empirically supported treatment models (e.g., Multi-Family Groups, Cogntive Rehabilitation Groups) to USH staff members. Finally, scientific papers resulting from the collaborative USH-BYU research projects began to appear once again at national and international conferences (e.g., American Group Psychotherapy Association, International Society for Psychotherapy Research) along with news reports appearing in AGPA publications (e.g., Group Circle).

We believe that USH has come "full circle" in reconnecting to our roots of offering and studying high quality group treatments. The renewed interest in group treatment of staff members on units that have participated in this program is promising and vital to an effective group program. The reconnection with BYU programs (clinical psychology, marriage & family therapy, & nursing) focusing on group treatments has already produced funded projects, scientific papers and a reconnection to the group literature to insure that we systematically incorporate proven group principles that result in high quality treatment groups. Finally, this manual is evidence of this renewed partnership and is offered as a limited guide to creating effective group programs and groups. We see the manual as a "work in progress" and hope that others in the hospital will not only use it but contribute to it as well.

Chapter 4

Definitions of Types of Groups

Group treatment at the Utah State Hospital is varied both in purpose and function. The different types of groups focus on varying goals and objectives and in turn necessitate different leadership competencies and patient composition. The group objective and goal will dictate the type of group. In the following chapter we offer definitions of each of the five types of groups. These types are:

1. Psychotherapy
2. Psycho-education
3. Skills Development
4. Counseling
5. Activity Groups
6. Diversional Activity

These group types, definitions, and standards are calibrated against the national standards proposed by the Association of Specialists in Group Work (ASGW). They have been modified to "fit" the USH environment and are offered to provide a common USH standard and language to facilitate discussion on group treatment.

Please note that for each type of group there are certain training standards that need to be maintained. For additional information on a particular type of group please refer to their individual chapters in the latter part of the manual.

Psychotherapy Groups

Definition: Group psychotherapy is designed to precipitate change in a person's deep-seated affective, cognitive, or behavioral functioning. It identifies maladaptive attitudes and beliefs that are now dysfunctionally manifested in the individual's present. Group psychotherapy focuses on both the content and the process of discussion; what group members say and how they say it; the dynamics of relationships formed in the group and how these are representative of groups members' coping or avoidant styles. It is characterized by high levels of "cross-talk," self-disclosure, and psychological "risk-taking".

Structure: Group psychotherapy can be either open–ended or time-limited. Groups typically meet once or twice weekly. It is recommended that the group have no less than 6, and no more than 10 members. Ideally, group psychotherapy should be conducted by co-therapists. Because such group explore in-depth psychological problems, they are typically designed for the "higher –functioning" hospital patients. However, some psychotherapy models (cognitive rehabilitation) can effectively deal cognitively impaired patients. A pre-screening of candidates for the group is recommended to ensure that the group will meet the patient's ICTP goals. All groups should subscribe to particular theoretical models that match the leader's training and skill and the patients needs.

Skills & Competencies: Therapists should have a strong background in abnormal psychology, child and/or adult development, assessment and diagnosis, and group process. Proficiency in at least one psychotherapy model is required. Therapists should be able to recognize inter- & intra- personal dynamics and use problem solving approaches in groups, intervene in crises, work appropriately with disruptive group members, develop hypothesis about nonverbal behavior, use pacing strategies, and assist in individual change in behavior.

USH Professional Training Standards: A master's degree and/or license in social work, psychology, marriage and family counseling, psychiatric nursing, or counseling psychology; psychiatrists. Groups can also be conducted under supervision by graduate interns of the aforementioned disciplines.

Examples:

Adults Molested as Children
Women's Issues
Interpersonal Communication
Dual-diagnosis (Axis I & Substance Abuse)
Borderline Personality Disorder

Psycho-Educational Groups

Definition:

Psycho-educational groups focus on providing relevant information and training to its members accompanied by interpersonal discussion in order to enhance group members understanding, development and decision making. Such groups emphasize cognitive, affective, and behavioral development through a structured, sequenced set of procedures or exercises within and across sessions.

Psychoeducational groups have one of three purposes: primary or secondary prevention or remediation. Primary prevention groups are pre-emptive by nature serving as a medium to educate group participants who are presently unaffected about a potential threat (i.e. AIDS education), a developmental life event (i.e. parenthood, retirement, etc.), or how to cope with an immediate life crisis (i.e. loss of a loved one) with the goal of preventing an array of educational and psychological disturbance from occurring. Secondary prevention groups are to prevent a relapse into a past behavior (i.e. relapse prevention). Remediation groups are to help patients acknowledge and change self-defeating or dysfunctional behaviors (i.e. substance abuse). Most psycho-educational groups at the hospital are either remediation or secondary.

Structure:

These are inherently time-limited groups with a well defined beginning, middle and end. They should be held at least 1-2 times a week with a size of 7-12 members. Topics should be specific and match the patients needs and ICTP goals. The intent of psycho-educational groups is to equip group members with the knowledge and skills that they may need to better cope with life events and reduce risk or relapse.

Skills/Competencies:

The group leader should have background knowledge of material being presented, a familiarity with group process (especially group development) and a detailed outline of course content and session objectives. The group leader should select members based on the topic relevance to their treatment needs and be able to use the environmental dynamics to benefit the group.

USH professional training standards:

Psycho-educational groups should be run by individuals with an educational background in the area to be presented. Professional licensure and an academic

degree are required to lead these groups for Nursing, Occupational Therapy, Recreational Therapy, Social Work, or Psychiatry. Student interns and Psychiatric Technicians under the appropriate direct supervision of the above professional are also eligible to lead these groups.

Examples:

Recovery From Psychosis
Symptom Management
Anger Management
Understanding My Diagnosis
Health Management

Skills Development Groups

Definition:

Any organized group activity that assists individuals to develop competence in basic living skills in the areas of food planning, shopping, food preparation, money management, mobility, grooming, personal hygiene and maintenance of the living environment, and that assist patients in complying with their medication regiment, or activities that develop social and interpersonal skills and appropriate behaviors.

Recreation Groups

Structure:

There should be a minimum of 10 activities per week but this number will vary based on level of functioning and severity of illness in patient. The groups size will vary per activity and number of support staff however most will be between 3-10 members.

Skills & Competencies:

Group leaders should be able to maintain attention on task, establish clear goals, manage conflict in groups, and utilize group decision making methods.

USH Professional Training Standards:

MTRS, TRS, TRT, or TR Intern under the supervision of a MTRS, or TRS.

Examples:

Trust/Initiative activities
Leisure education activities
Community re-integration activities
Physical Education (If focus of activity is on improving interpersonal skills such as teamwork, sharing, problem solving).

Psychiatric Technician Groups

Structure:

These groups should be held at least once per week and should have a ratio of 1 staff to 5 group members. The groups should be at least 30 minutes and cover a specific topic. There should be a planned structure for the group that is

approved by the unit SMT.

Skills & Competencies:

Trained staff working under the supervision of a licensed registered nurse. Must have group approval by unit SMT and attend unit process meetings.

Examples:

Activities of Daily Living
Cooking skills
Literacy
Music Appreciation

Counseling Groups

Definition:

These groups address common problems of living in an informal fashion. With attention directed to external causes of problems, group and individual problem-solving competencies are developed. Emphasis is placed on affiliation and support for others. The objective is to manage stresses and obstacles in day to day experiences to bring about behavioral change conducive to more effective daily functioning.

Structure:

These groups should be held at least 1-2 times a week. The average group size should be 6-10 patients but can be larger if there is a demand. Most of these groups are open -ended. A co-therapist is recommended to ensure consistency. Topics of the groups should be ICTP driven and goal oriented. They should focus on a particular area that is relevant to all the group members.

Skills & Competencies:

The group leader should select members to include heterogeneous psychiatric problems. The group leader should be able to understand the interpersonal dynamics involved in group counseling, apply group problem solving approaches, recognize self-defeating behaviors in members, and intervene effectively with critical incidents and disruptive group members.

USH Professional training standards:

Licensed psychologist, Licensed Clinical Social Worker, Clinical Social Worker under direct supervision of a LCSW, or Clinical Nurse Specialist

Examples:

Stresses of living in the hospital
Relationships with spouse, family, friends
How to work with community resources
Taking charge of my life
My illness and my employer
How to get my medication adjusted
Sunrise Program
Community meetings
Alcoholics Anonymous

Activity Groups

Definition:

Activity Groups are designed to provide patients with experiential or real life activities in either of two ways: 1)one-time-only activities, or 2) repetitive (procedural), routine (daily of several times a week), consistent (predictable) activities. These groups may take place on campus or off groups (community) in a controlled and prescribed way. Application of learned skills (practice or maintainance) or experiential learning is emphasized.

Structure:

There may be diversity in the structure of these groups. Generally 2 to 10 patients may participate in these activities at a time with variation in number of staff depending on patient need. Occasionally these groups may be hospital-wide activites with increased numbers of patients and staff.

The structure of the group sessions should follow professional standards and practice for content and therapeutic interventions.

Skills and Competencies:

Leaders utilize theory and practice of their given profession in program planning and providing therapeutic treatment. Group leaders should have background knowlegde of material being presented and skill in managing groups. Assistant leaders (who do not posses academic training) must meet specific leadership competeincies.

USH Professional Training Standards:

Professional licensure and an academic degreed are required for leadership of these groups. Assistant leaders (who do not posses academic training) maybe eligible to co-lead groups if they operate under the direct supervision of the qualified leader and are able to meet specific leadership competencies.

Examples: (not inclusive in scope)

Grocery store	Excel House Program
Out to lunch	Breakfast group

Shopping (on grounds or off grounds) Leisure activities
ADLs (personal hygiene, grooming, and care of living space)
Laundry Bus trips

Diversional Activities

Definition:

Diversional activity if designed to provide patients with tasks of interests for entertainment, engagement, and/or personal need.

Structure:

Diversional activities can be impromptu or well-planned but require prior approval and supervision by appropriate supervisors. The scheduling of groups may vary due to the spontaneous nature of the activities. These groups may take place on campus and off grounds.

Skills & Competencies:

Professional training is not required for the group leadrs. Leaders need to meet specific competencies for managing groups on campus and off grounds. The activities should be well supervised and documentation requirements met.

USH Professional Training Standards:

Group leaders need to meet specific competencies and be under the supervision of appropriate professional staff.

Examples:

- Van Rides
- Sport activities
- Bingo
- Unstructured crafts
- Unstructured exercise
- Cooking
- Canteen
- Games
- Puzzles

Individual Treatment Activity- ITA

Definition:

Individual Treatment Activity is provided for a patient who, for various reasons, does not attend his/her regularly scheduled group session. The activity can focus on diversional, skill, or activity group content depending on the patient's needs or the qualified staff available.

Structure:

Individual Treatment Activity requires prior approval and supervision by appropriate supervisors. The activity takes place on the unit only.

Skills and Competencies:

Professsional training is not required for the group leaders. leaders need to meet specific competeinceis for providing treatment to individual patients. Leaders should have backgroupnd knowledge of material being presented or of the tasks being performed. The activities should be well supervised and documentation requirements met.

USH Professional Training Standards:

Group leaders need to meet specific competencies and be under the direct supervision of appropriate professional staff.

Examples:

Laundry
Games
Hygiene and grooming
Careof living space
Daily planning
Cooking

Chapter 5

How to Develop a Unit Group Plan

Overview

The development of a planned group therapy program requires a clear and strategic organization in order to be successful. Above all, the goal of such a program is to deliver quality services to a variety of patients while managing limited resources. This process consists of several phases and is based on a number of key concepts.

The first portion of this chapter discusses two concepts that are essential to prioritizing and planning group processes from a management perspective. These concepts address issues such as group designations, resource allocation, and the roles of various disciplines in the unit group program.

The second part of this chapter is meant to assist in implementing successful group plans on a unit basis. It has been organized using the APIE format to link the group programs to the Quality Improvement (QI) process. To further demonstrate the process of developing a group plan a prototype of a unit group program is illustrated as an example.

Organizing framework for group programming

Before work can begin on organizing or reorganizing a unit group program, two fundamental principles or working assumptions are presented. These concepts are used throughout the remainder of the implementation process.

All groups are not of equal importance on the unit. This principle is not meant to devalue any particular group leader on a unit. Rather, it is to assist unit staff and leadership to prioritize staffing of groups. There are many situations (e.g. DOS, staff shortages) that lead to staffing challenges. Unit group programmers should have a clear understanding of which groups are essential to patient treatment (ICTP driven) and which are supplementary. Participants should also have a clear understanding of the importance of core groups to their treatment.

Staff members will have varying levels of experience and training in conducting different patient groups. For instance, some staff may have never run a group or received any formal training while others may only have outpatient experience. Considerations of this sort, while secondary to unit group curriculum, are factors that will influence the success of a unit group program.

Group Designations

When prioritizing resources and scheduling for unit programming, it becomes obvious that some groups are more closely tied to ICTP objectives and thus are more critical to patient outcomes than others. By categorizing groups based upon their priority rather than approach or goals, the programmer is able to reference groups according to

the level of resources to be allocated to them. There are three such categories, (see table one) which are described below. These designations can be helpful in assisting unit leadership in making decisions about staffing, development, and maintenance of groups.

CORE GROUPS

These groups represent the central group curriculum for the unit. They focus on areas of need for most patients regardless of diagnosis or presentation. Often, discharge criteria or skill deficits of the general patient population necessitate these groups. As such, Core groups are offered on a regular and repeating basis. The content will likely be presented by one or all disciplines and should be considered essential for patient treatment. While they are potentially few in number, Core Groups are the basis for unit programming. They are considered top priority and should receive the most attention from unit leadership. These groups should be scheduled at times that are unlikely to conflict with incidental activities. Staff being assigned to Core Groups should understand the importance of the assignment and should strive for consistency both in holding group meeting and in patient attendance. Having a co-therapist is often helpful in ensuring that the group is held in the absence of one of the leaders (sickness, court, vacation, etc.). Core groups are based upon clearly articulated clinical indicators. They are established in response to patient need. Limitations based on resources should be overcome to ensure that these groups are always provided.

TARGET GROUPS

These groups are designed to address specific problems related to diagnosis or population. For example, groups to address substance abuse or depression disorders often fall under this rubric. Patient attendance in these groups are as important as the Core Groups. Target Groups are implemented whenever a sufficient number (4-5) of homogenous patients are identified. Multiple units could combine to offer services where designated populations do not warrant a group on each unit. It can be noted that in Table 1 that when possible these groups should be co-led to ensure a continuity of care.

ELECTIVE GROUPS

Groups in this category address secondary needs of the patients and are variable in availability. Such groups could include special interest topics or groups offered by volunteers, students, or community professionals. There should be a number of these groups being held concurrently on the unit. Moreover, staffing of Core and Target groups should take precedence over elective groups.

Table 1

Group Designation Reference

	Core Groups	Target groups	Elective groups
Definition	While few in number, all patients attend at least one Core Group. ICTP goals are essential when making group assignments.	These groups are focused on specific issues for a targeted population (E.g. those with substance abuse problems or Axis II diagnoses.) Homogeneous in respect to symptoms and /or level of function.	These are topic specific groups. They are created and maintained based on patient interest and staff competency.
Staffing	These groups should be co-led. When unit demands increase, they are not canceled. For example, if one group leader is needed for a crisis, the other leader can run group	These groups are scheduled according to population needs. Ideally, they should have two leaders to ensure continuity for the duration of the group	Coverage for these groups is flexible. If any groups need to be canceled-it needs to be an elective
Specifics	These groups can be time limited, e.g. a psycho-educational group that is limited to 4-8 weeks. They are repeated often and are offered by all disciplines.	These groups are for specific subgroups of patients. (e.g. those with personality disorders attend Axix II treatment issue groups while those nearing discharge attend community re-entry groups.)	These groups should be run in such a way that they are flexible and responsive to patient schedules and availability. These are likely to be popular and well attended.
Examples	Community mtg. Psycho-therapy Symptom mgt. Medication	Recreational Therapy Sunrise Program Excel House Borderline Skills	Hobby Groups Cooking skills Group Art Appreciation

Anger Management Reading Group
ADLs

Table 2

Crossing Types of Groups with USH Group Destination System

Type of Group	Core	Target	Elective
Psychotherapy	Example: Cognitive Behavioral	Example: Borderline Group	
Psychoeducational	Example: Medication mgmt.	Example: Anger mgmt.	
Skills Development	Example: Goals	Example: ADL groups	Example: Cooking
Counseling	Example: Community meeting	Example: Sunrise group	Example: Alcoholics Anonymous
Activity/Diversional Activity	Example: Excel House	Example: ITA, Laundry	Example: Van rides, movies

Table 2 reflects the intersection of the USH group classification system with the aforementioned ASGW definitions for type of group. Cell entries in Table 2 reflect actual USH groups that are being run on a number of units. The shaded area in the table indicates cells where no groups should be scheduled. An explanation of a few of the cells in Table 2 follows that should be useful in illustrating how the table might be useful in facilitating unit group programming.

Since psychotherapy and psycho-educational groups are resource intense activities you will note that the use of these types of groups as ELECTIVES is excluded from Table 2. Stated differently, all psychotherapy and psycho-educational groups held on a unit should have direct relevance to the patients' ICTPs and thus will, by definition, be listed as a core or target group that is held on a consistent basis. There are no elective psychotherapy or psycho-educational groups.

A second example from Table 2 can be found is an anger management group. Please note that Table 2 places this group in the psycho-educational/target group cell. In this instance, the group might be used to address a targeted group of patients by DIAGNOSIS (e.g., conduct-disordered children) or unit behavior (patients who have recently engaged in violent behavior). By referring to the psycho-educational group chapter that is placed later in the manual, the USH staff member will note that this type of group is typically very structured and content-driven. In fact, most psycho-educational groups have a session X session content flow that very much parallels a "class-like" environment.

However, by placing anger management in the psycho-educational/target group cell in Table 2, we do NOT want to suggest that this is the ONLY appropriate designation for this type of group. For instance, a unit with a high number of patients with the diagnosis of borderline personality disorder might offer an anger management group that could easily be classified in the psychotherapy/core group cell of Table 2. Thus, what is most important about Table 2 for unit group programming is to declare HOW the unit views the group (core, target or elective) and WHAT type of group content, structure and process can be expected (psychotherapy, psycho-educational, counseling, skills & activity). The added clarity that this will provide will undoubtedly assist in resource allocation and identifying who can competently lead groups on the unit.

ASSESS

Needs assessment

All unit group programming should be directly tied to the needs of the patients on the unit. This part of the development of a group plan is crucial to forming a suitable plan. The information gained will be essential to the next step of this process and should be thorough and complete. This should be based on both demographic data and a subjective poll of staff/patients. Areas which should be addressed in the needs assessment include:

- Diagnosis
- Presenting problem
- Level of function
- ICTP goals

Resource assessment

Each unit should also assess the resources available on the unit. This will help identify the capability of each unit to staff their unique group program. These may include:

- Patient privilege levels
- Competence/Training of potential leaders
- Available materials
- Facilities
- Staff Coverage

EXAMPLE

1. Assessment of current group program

   Determine which treatment groups exist on unit and categorize into one of the five categories (see table 1)

   - Skills Development
   - Counseling
   - Psychoeducational
   - Psychotherapy
   - Activity

Once categorized, further examination can be made to determine whether the group is one of the following:

- Core
- Target
- Elective

2. Assessment of patient population

   Determine the type of patient population categorize by diagnosis and frequency

of axis1 and axis 2 diagnosis

Treatment team can then analyze data to determine most common diagnoses and major diagnostic categories eg. Mood disorders, psychotic disorders, etc.

3. Review best practice research and implementation. This can provide invaluable assistance in identifying the most effective treatments for particular disorders.

4. Review national standards for best practice and research recommendations for the assessment and treatment of each diagnosis.

5. A unit may want to form committees for each identified diagnosis to review possible interventions in therapy (individual, family, group), medications, and programming.

Unit Needs Assessment (Adult Unit)

This assessment has been based on information readily available in the patient charts. It has been formulated to address patient programming needs by examining the presenting problems of the patient population as stated in pre-admission assessments and individualized comprehensive treatment plans (ICTPs).

Procedure

Data Collection: A spreadsheet was used to track the data and organize responses in useable categories. The table was similar to the following:

Patient Function	MHC Needs	Dx	Strengths	Needs	ICTP Goals	Objectives	Modalities
WA high	review medication	major depression	mechanic repair		depression	stable on meds	take meds	meds
WA	increase insight	alcohol abuse	cooking	suicidality	increase insight	verbalize insight & reduce anxiety	staff teaching
WA	increase self-esteem	cannabis abuse	taikwando	insight	eliminate suicidality	no suicidality	ind. Therapy

The items were selected based upon availability as well as saliency in describing the clinical condition. A brief description of each item follows:

Patient: Identifying information was included on each line to maintain coherency of records when the database was sorted.

MHC Needs: Mental Health Center needs as drawn from the pre-admission assessment. This item is listed as criteria for discharge in that document. It is intended to reflect the community perception of the patient's condition as well as the expected outcomes for the local care provider. Entries were condensed to allow for easier categorization.

Dx: A listing of DSM IV diagnoses as listed in the current ICTP.

Strengths: Listed in the ICTP intended to provide information about patient resources related to various treatment modalities. Also could be used to help identify the feasibility of groups based on shared patient resources.

Needs: These are included in the ICTP to assist in formulation of long term goals. Correlates highly with MHC needs as well as ICTP Goals.

ICTP Goals: Drawn form the ICTP Long Term Goals. Once again this represents a condensed version of treatment team intent.

Objectives: Each discipline objectives were compiled to track correlation with ICTP Goals.

Modalities: A compilation of modalities listed as presently used to obtain Objectives and ICTP Goals.

Function: This is a subjective rating of insight and ability to function in a group setting. Used to establish educational level of programming needs.

Each patient's ICTP was reviewed and the necessary data transcribed onto the spreadsheet. This process took approximately six hours to digest and compile. The process was assisted by the participation of the unit secretary in entering the data. Upon completion, the data then needed to be sorted and further condensed.

Data Preparation and Coding:

The spreadsheet data was sorted according to item and various lists were generated. Due to the lack of numeric data, a subjective analysis was required. The first step of this process was to establish a common terminology. The lists were examined and general groupings were identified. This resulted in an abbreviated list of approximately fifteen responses. As sample result of one such an analysis follows:

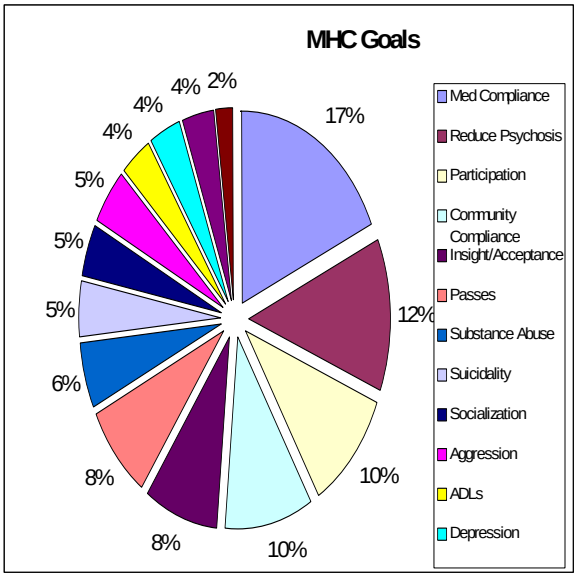
Condensed response list for item: MHC Needs

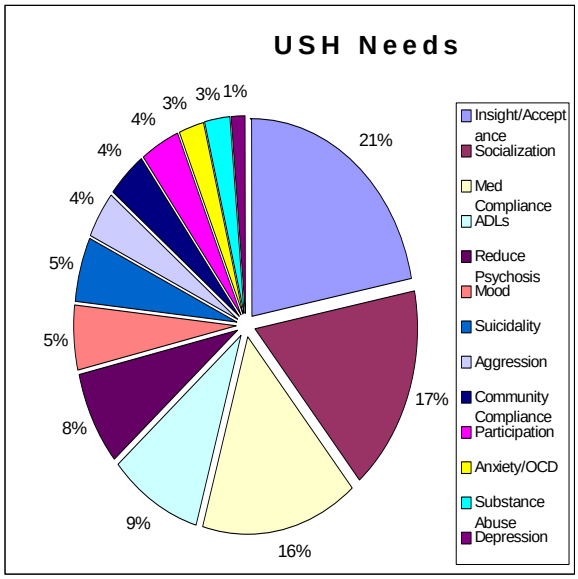
Med Compliance	20
Reduce Psychosis	14
Participation	11
Community Compliance	11
Insight/Acceptance	9
Passes	9
Substance Abuse	6
Suicidality	5
Socialization	5
Aggression	5
ADLs	4
Depression	4

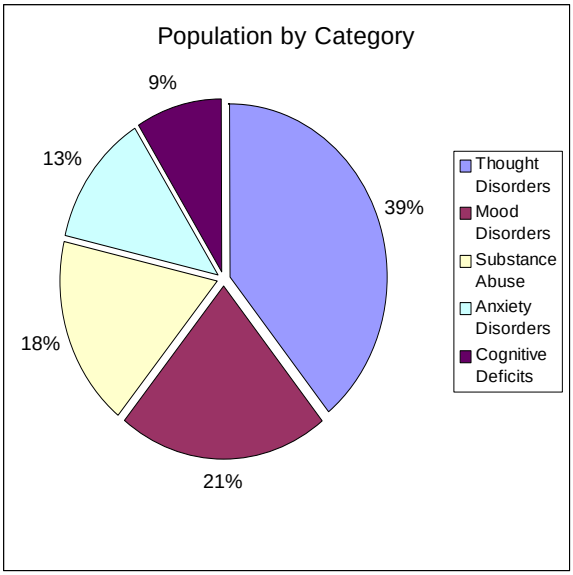
Independence	4
Anxiety/OCD	2

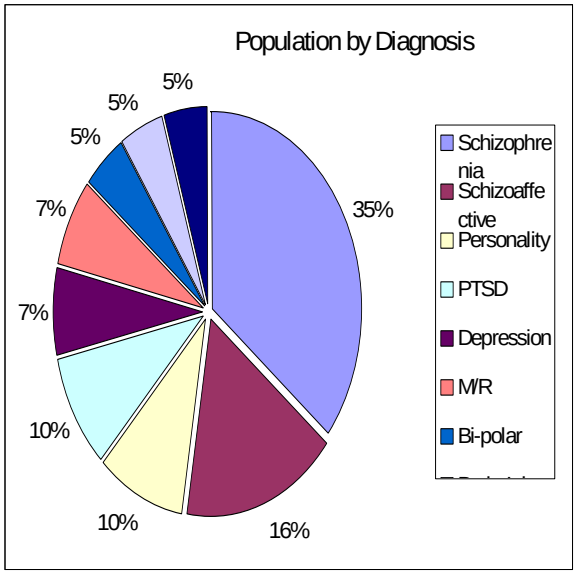
Preparing for Assessment

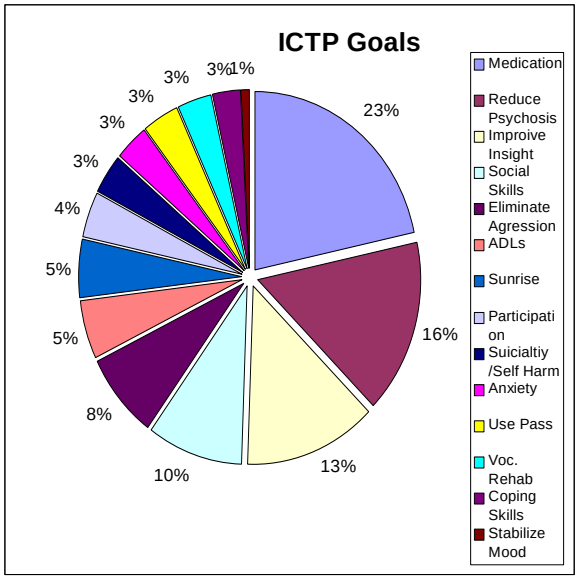
Once the data was in this format, it was a simple task to compile charts to assist in visual assessment of the data. Excel is capable of creating various types of charts by highlighting the data range and using the Chart Wizard. The results of the data example follow:

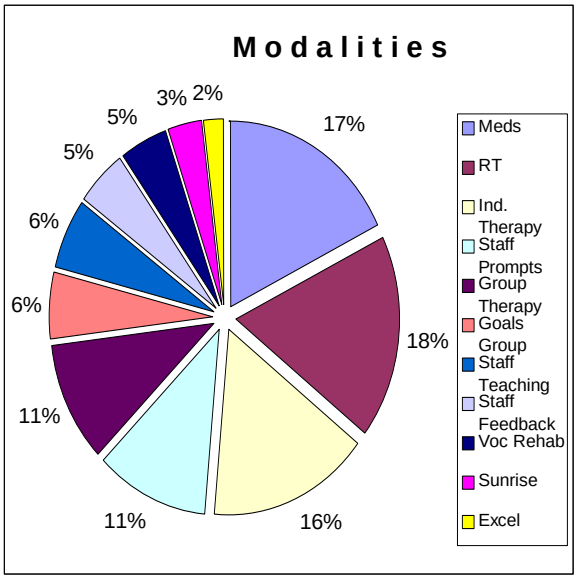

MHC Goals
17%
12%
10%
10%
8%
8%
6%
5%
5%
5%
4%
4%
4%
2%
Med Compliance
Reduce Psychosis
Participation
Community Compliance
Insight/Acceptance
Passes
Substance Abuse
Suicidality
Socialization
Aggression
ADLs
Depression


USH Needs
21%
17%
16%
9%
8%
5%
5%
4%
4%
4%
3%
3%
1%
Insight/Acceptance
Socialization
Med Compliance
ADLs
Reduce Psychosis
Mood
Suicidality
Aggression
Community Compliance
Participation
Anxiety/OCD
Substance Abuse
Depression


Population by Category
9%
13%
39%
18%
21%
Thought Disorders
Mood Disorders
Substance Abuse
Anxiety Disorders
Cognitive Deficits


Population by Diagnosis
5%
5%
5%
7%
7%
10%
10%
16%
35%
Schizophrenia
Schizoaffective
Personality
PTSD
Depression
M/R
Bi-polar


ICTP Goals
23%
16%
13%
10%
8%
5%
5%
4%
3%
3%
3%
3%
1%
Medication
Reduce Psychosis
Improive Insight
Social Skills
Eliminate Agression
ADLs
Sunrise
Participation
Suicialtiy /Self Harm
Anxiety
Use Pass
Voc. Rehab
Coping Skills
Stabilize Mood


Modalities
17%
18%
16%
11%
11%
6%
6%
5%
5%
3%
2%
Meds
RT
Ind. Therapy
Staff Prompts
Group Therapy
Goals Group
Staff Teaching
Staff Feedback
Voc Rehab
Sunrise
Excel

Plan

Once a unit has done a thorough assessment of needs and resources, they are ready to begin planning their group program. There are two main issues to be considered when planning the group program designating the type of group and scheduling.

Designation of groups

Groups should be chosen based on the assessment data of the patient's needs. The group plan should include all five types of groups (psychotherapy, psycho-educational, skills development, and counseling, activity) and include all three categories of groups (core, target, and elective). Groups should match the patient population and staff ability

Minimum Program Recommendations

Each patient should be involved in a group treatment program similar to the following:

2-3 Therapy Groups (Core and/or Target)
1 Social Skills (Core)
1 Medication Management (Core)
1 Leisure/Recreation (Core)

Scheduling

This may be the most difficult part of developing the group program. There are many design possibilities for each individual unit. The main goal to strive for is a consistent group plan. This will help the patient remember group time and provide a routine to avoid cancellations. It is recommended a group plan be scheduled and posted on the unit to inform all staff and patients of group times.

Implement

After a complete group plan is developed it is time to implement it on the unit. As stated each staff member has different levels of training and will need support in varied amounts. The hospital has developed and implemented many infrastructures to assist in the creations and maintain a group program on the unit. Along with your planning and the hospital's support a valuable group program can be set in place. There are supports for a group program at the USH. These include:

1. *The unit group plan developed by the SMT and staff*

   The Unit plan should offer a complete group treatment to the patients to help with recovery, relapse prevention, and readiness to discharge.

2. *The group consult meetings*

   The weekly group consult meetings are a time for staff to instruct others on group principles and techniques. It also provides an opportunity for staff to process their own group's progress. This can be an ideal time to supervise group leaders that have not run groups in the past.

3. *Group coordinators*

   The group coordinators have been selected due to the expertise and/or interest in group treatment. They have additional resources for groups and are themselves a resource to other group leaders. They can provide additional material and guidance.

4. *Group resource manual*

   The group resource catalog is included as an appendix in this manual. It includes a listing of all the group material at the state hospital and the location of the material.

Evaluate

There are several ways a unit can evaluate a group treatment's efficacy. The most basic measure is to evaluate if the groups are being held in a consistent manner. If a group is not being held then no patient improvement can result. E-chart can help by serving as a tracking system that can be used to monitor the consistency and quality of groups on the unit.

A unit can also evaluate using patient outcomes. **The Brief Psychiatric Rating Scale (BPRS-E)** is a 24- item instrument designed to assess the severity of psychiatric symptoms. It is given in an unstructured interview by a qualified rater and was developed to provide a rapid assessment technique of patient change (Overall & Gorham, 1962). The BPRS is administered at the hospital by the psychology department and the results can be accessed on the LEMUR system. The **Life Status Questionnaire (LSQ)** and the **Youth Life Status Questionnaire (Y-LSQ)** are semi-parallel child/adolescent and adult instruments used to track the symptomatic improvement of patients receiving mental health services. The measures have 45-LSQ and 30-Y-LSQ items each and take approximately 5-8 minutes to complete. They have been shown to be very sensitive to changes due to treatment in outpatient and inpatient settings alike and have good reliability (alpha coefficient above .90) These measures are administered by the social worker at the hospital and can also be accessed on LEMUR.

Another method of evaluation is to focus on the groups themselves. Using the Self-Satisfaction Scale (SSS) you can evaluate patient satisfaction with YOUR group. This SSS assesses participant's satisfaction level, as well as their problems with the group. It is a 10-item instrument measured on a 5-point scale with adequate reliability (.78). The instrument and scoring instructions are included in the appendix.

Another aspect of the group you can evaluate is the group's functioning. The **Hill Interaction Matrix (HIM-G)** is one of the most frequently used measures of group process in the extant literature. Interestingly, this measure was originally designed at the Utah State Hospital in the 1960's to track the quality of therapeutic interaction inherent in group treatment. The instrument is composed of a 72-item rating scale that is completed by a trained group observer. Several staff members in the hospital have already participated in the HIM-G rating system The rating scale is included in the appendix and raters are available per your request. The **Group Climate Questionnaire (GCQ)** is a self-report measure designed to document the stages of early to mid-group development. It is a 12-item measure which is rated by group members on a 7 point scale and takes approximately 5 to 10 minutes to complete. Three subscales are produced: Engaged, Avoiding, and Conflicted. The Engaged scale examines cohesion, self-disclosure, cognitive understanding, and confrontation within the group. The Avoiding scale measures the amount of avoiding of responsibility of the various group members in the process of change within the group. Interpersonal conflict and distrust are surveyed

within the Conflict scale. The instrument and scoring instructions are included in the Appendix. It does not matter what you use but **some** method should be implemented to evaluate the group.

Chapter 6

Group Organization

Steps in developing a group

Once a staff member has been assigned to lead or co-lead any type of a group, he/she needs to assess, plan, implement and evaluate the organization of that group. The ability to understand and complete each of these steps is critical for a successful group.

Assessing the Type of Group Experience Needed

Prior to the initiation of any group experience, the leader(s) must understand the reason for why groups are a beneficial part of the psychiatric unit's treatment philosophy (Janosik & Phipps, 1982). When looking at the Utah State Hospital's treatment philosophy and how groups are a part of this ask the following questions:

1. What is the target population(s) in the treatment setting? What are common diagnoses and symptoms seen in treatment?
2. What type of a treatment philosophy will be used?
3. In general what are the goals for providing treatment to the target populations?
4. How will these goals will be accomplished?
5. How are philosophies incorporated into each individual patient's treatment plan?
6. How do group experiences fit into the treatment philosophy?
7. What benefits can groups provide for the target population? Are there any risks?
8. What specific types of groups would be the most useful?
9. What skill level and experience is needed for the leaders of these groups?
10. How can groups meet individual patient treatment needs and interests?

Planning for the Group Experience

Careful planning must be done prior to starting a group. Many areas must be addressed during this planning phase. Areas to plan are based upon the above assessment but also include:

selecting a leader and if desired a co-leader
the theoretical framework to use for the group
the purpose of the group the group
goals and objectives; membership selection
patient preparation
physical setting for the group.

See Table 1 as a worksheet for planning the group experience.

Theoretical Framework for the Group:

When the assessed needs for a group have been identified, the group leader(s) must look at what theoretical framework will best fulfill meeting the identified needs. A theoretical framework is a set of concepts and principles that guide the direction of the group experience. Several frameworks are available to choose from. Psychoeducational frameworks are used when a group's intention or purpose is to provide educational experiences for group members. The framework chosen will also be based upon the training of the group leader in their respective discipline.

The Purpose, Goals, and Objectives of the Group:

The purpose of the group refers to the intention or aim for why the group is being planned and initiated. The purpose of the group should be strongly linked to the theoretical framework.

Once the purpose of the group is defined it allows the group leader to successfully set group goals and objectives. Goals provide the group leader with an end product of what needs to be accomplished within the group. This includes the knowledge, skills, or attitudes that the leader wants the group members to accomplish, therefore meeting patients needs. There are two types of goals that must be addressed. These are short term and long term goals.

1. Short term goals are those that will be addressed within a specific group session(s) or activity(ies).
2. Long term goals are those that will be accomplished once the group members have either completed the group experience or are discharged from the hospital (Dyche, 1988).

When writing goals, the group leader must always state the behavioral outcomes of the goals. These behavioral outcomes need to be measurable. In order for a goal to be measurable, the group leader must be able to provide proof that there is a change in a patient's behavior from when the goal was set to when the goal was completed. (Wood & Seymour, 1994, page 19).

Goals only provide the group leader with general guidelines for the group experience. Objectives provide specific requirements for how the goal(s) will be accomplished. Objectives have several purposes and advantages. These include:

guiding the group leader towards the specific contents to include in the group meeting

helping the group leader to stay on target and not deviate

helping the group leader to communicate specific requirements or steps to the group members

providing standards to help the group leader in measuring the outcomes of the goal(s) (Dyche, 1988).

Goals and objectives for any group experience need to be part of each patient's Individual Comprehensive Treatment Plan (ICTP).

Membership Selection:

According to Yalom (1985) there is scarcely any patient who will not benefit from a group experience. The idea is to match the patient with a group that will most likely meet his/her needs. It is recommended that the final decision for group membership selection be done in unit staff meetings where the entire treatment team can provide feedback.

When selecting group members, *homogeneous verses heterogeneous characteristics* are decisions that the group leader needs to make according to the needs and purpose of the group. In homogeneous groups, the members have similar characteristics while in heterogeneous groups, the members have differing characteristics. Yalom (1985), claims that homogeneous group work better for noncompliant patients. Also there is some evident to suggest that individuals with chronic mental illnesses such as schizophrenia are best treated in homogeneous groups (Chambliss, 1988). Some additional advantages of homogeneous groups involve group members becoming more cohesive, more supportive to one another, having less conflicts, and members having more rapid relief of symptoms.

Heterogeneous groups have their advantages as well. A group with some heterogeneous characteristics enables group members to learn from one another. Heterogeneous group works best if the group members are meeting for an extensive period of time (Yalom, 1985).

Group leader needs to decide if the group will be an open or closed group. Open groups are those that accept new members and allow members who have met the group goals to leave when needed. Open groups work well on an inpatient psychiatric unit because patients who are eligible for the group can come and go as they are admitted, discharged, or receive maximum benefit from the group. In some cases open groups are ongoing on the psychiatric unit and may last for months or years (Yalom, 1985). With open groups, the group leader needs to be careful that new members do not becomes confused and uninterested in subject material because they missed prior group sessions. Group leaders should make a special point to welcome and orient new group members. For an open group it may be beneficial to introduce two new members at a time so that they will feel more comfortable integrating themselves into the group (Wood & Seymour, 1994). An example of an open group would be a "Medication Teaching Group" where each week different types of medications are discussed. In this type of group, patients can come as needed.

Closed groups are those that do not allow new members to join and often meet for a predetermined amount of time. Closed groups work best on an inpatient psychiatric unit when specific orderly schedules have been set to accomplish the group goals and tasks. An advantage of a closed group is the increase in group cohesiveness since new members are not effecting the regular group members' interactions (Yalom, 1985). An example of a closed group is a communication group where specific skills are learned and practiced in a sequence of events.

To assist the group leader in membership selection, the leader needs to be aware of some basic *criteria for membership inclusion and membership exclusion* (Yalom, 1985

Inclusion Exclusion

Patient's ability to attend & participate	Acute stress or psychotic situation
Group helps pt.'s individual treatment	Cognitive ability
Some ability to follow group rules	AWOL risk
Desire for help with interpersonal problems*	Self Harm/suicidal

*Interpersonal problems may only apply to certain types of groups. For example a psychotherapy group may address patient problems such as social withdrawal, difficulty making friends, loneliness, shyness, inability to share feelings, inability to accept feedback, suspiciousness, abrasiveness, narcissism, or dependency

The size of the group will also affect membership selection. The recommended group size is five to ten members (Yalom, 1985). For example in a therapy group when group membership is under five, often the group members cease to come because the benefits of the group no longer exist. Groups of over ten are often difficult since the leader is unable to monitor that many members at once. In large groups, the members are less likely to get individual attention for their needs. *Preparing group members for the group* is a critical responsibility of the group leader. Each member needs to understand

1) why he/she has been selected for the group,
2) the purpose and goals of the group,
3) how the group can be beneficial
4) what will be expected within the group.

For best results, the leader should find out and include in the group the different members needs and interests as they address group topics. Members should be aware of other members who will attend the group, the date, time, and location of the group. Without good member preparation the group has a high risk of failing.

The Physical Setting for the Group:

The group leader is responsible for making arrangements for meeting times and places. Group sessions can be conducted anytime that it is convenient as long at the setting is free from distraction and allows for privacy (Yalom, 1985). It is important to not conflict with other treatment issues or groups in the milieu. *The length and frequency of meeting times* varies with each group depending upon the needs and purpose of the group. Whatever arrangements are made, the group leader must be consistent in conducting meetings as scheduled. Some groups may need to meet weekly while others are best done twice a week. In some cases, due to either specialized needs or short-term average lengths of stays, a group will meet daily. Group time can vary from twenty minutes to one and a half hours depending upon content and the member's ability to focus. Also, the group leader needs to decide if the group will meet for a specific number of weeks or if the group will be ongoing for many months.

The group leader must discuss with other staff members the most convenient times for the group so that the scheduled time does not interfere with other patient activities or therapies. Either before, during, or after deciding the meetings times, the group leader must decide on a *meeting location*. This decision rests with the physical outlay of the unit and the type of resources that the group needs. Meeting rooms that will best serve the group need to be selected.

Table 2, Components of Group Organization

Title of the Group:
Group Leader/co-leader:
Assessment of Group Needs:

Treatment Philosophy in regards to group experiences:

Identified Needs:

Resources Available:

Theoretical Framework for the group:

Rationale for framework used:

Purpose of the Group:

Short term goals:

Long term goals:

Membership Selection:

Rationale for heterogeneous or homogeneous group:

Rationale for open or closed group:

Criteria for inclusion:

Criteria for exclusion:

Group size and group members names:

Members expectations regarding rules on attendance, behaviors, etc.

Meeting Times:
Meeting Place:

Implementing the Group Experience

The table below gives a list of tasks that the group leader must do during the initial group session. There is no specific order in which these tasks are completed.

Tasks to be done within the First Group Session

1. Discuss the purpose and objectives of the group.
2. Introduction of group leader and members.
3. Discuss group leader and members expectations regarding group rules and norms.
4. Complete an activity or task to initiate the group's purpose and objectives.
5. Prepare group members for the next group session.

Implementing Additional Group Sessions: In order to provide a consistency in group structure and group members' outcomes, the group leader should use a similar format for all group sessions. The table on the following page gives ideas for how to implement and monitor each group session.

Evaluating the Group Experience

When all of the ideas, principles, concepts, and interventions are added together the group leader is able to determine how successful his or her group has become. This is known as the evaluation process. An extensive evaluation of a group process experience includes looking at many different outcomes. Since evaluation processes are so numerous, only some of the major areas will be addressed in this chapter.

Evaluation of the Group's Purpose: One of the first and most important areas to evaluate in a group is the group's achievement towards its purpose.

1. Are group members better able to develop and use new skills?
2. If the group members are learning new skills, how much of an improvement has occurred in what amount of time?
3. How are the improvements in the skills measured?
4. What specific interventions help to achieve the group's purpose?
5. How do group members view their progress within the group?
6. What specific improvements can group members identify?
7. What alternative interventions can be done prior to the termination of the group?

The above questions are just a start in evaluating if the group is achieving its purpose. These questions need to be asked by the group leader and the group members throughout the group process experience. If the questions are only addressed towards the end of a group then it is to late to make changes and see improvements in behaviors.

Evaluation of the Group Content (Planned Goals, Objectives, Modalities, and Interventions): For each group session, the group leader must evaluate if the group's content is aimed toward achieving the group's purpose. The content for the group is the actual subject material that is used to bring about group experiences. The subject material includes goals, objectives, modalities, (i.e. tasks, activities) and interventions that are used in working towards the group's purpose.

1. Are clear goals and objectives established for each group meeting?
2. Do the group members understand the goals and objectives so that they can easily work toward achieving the goals?
3. What specific interventions are planned to bring about the goals and objectives?
4. What specific results do the interventions provide?
5. If the activities and interventions do not provide desired results, the leader needs to look at why this in not happening. Have group members provided specific feedback about such?
6. What alternative activities or interventions can be used?

Evaluation of the Group Process: Process refers to the behaviors, emotions, unconscious goals, and other forces that influence the group towards or away from the group goals (Janosik & Phipps, 1982). The group's process is one of the most difficult items to evaluate since it includes such a large and comprehensive amount of interactions within the group. To evaluate the process of a group one must look at all of the behaviors, emotions, and interactions that occur with the group.

1. How do these behaviors, emotions and interactions effect the group?
2. What behaviors create movement towards the group's purpose and how so?
3. What behaviors create movement away from the group's purpose and how so? What interventions bring the group towards or away from meeting the goals and objectives?

Evaluation of Specific Group Members: The group leader is responsible for providing an ongoing assessment and evaluation of each group members progress within the group. Group leaders are required to document each member's progress in the group. As the group leader writes a summary of an individual member's progress, the leader needs to provide answers to the following questions.

1. What role or roles did the individual group member use during the group?
2. How did this role(s) assist the individual to achieve the group goals?
3. In what specific ways has an individual group member's behavior changed while being in the group?
4. What interventions brought about these changes?
5. Have the behavioral changes by the individual group member helped him or her progress towards achieving the purpose and goals of the group?
6. If behavioral improvements are not occurring what alternative recommendations can be done to assist the group member to accomplish the group goals?

Evaluation of the Group Leader: No group is effective without an effective leader. The group leader needs to evaluate himself or herself. Part of the leader's evaluation process is to receive feedback from group members on their perception of how the leader performed.

1. Do the group members feel comfortable around the leader?
2. Are they able to ask questions and make comments in a supportive environment?
3. Are the group members satisfied with the leader's style for providing information and interventions? If not why?
4. What recommendations do group members have for their leader?

Besides how the group members feel about the leader, the leader of a group needs to do a self-evaluation. This evaluation needs to include how comfortable the leader feels with the group and its cohesiveness.

1. Does the group leader feel that he or she is using good communication and customer service skills with group members?

2. Does the group leader feel that he or she is making changes for the better in members' behaviors?
3. Are appropriate interventions being used?
4. What things could be done differently?
5. What does the group leader feel that he or she is learning from this experience?

Since evaluation is an ongoing process, the group leader and its members must continually evaluate the progress of the group. Through the use of a consistent evaluation process, the group can identify problem areas and then examine ways to correct the problems. In this way the group can move towards its designed purpose.

Chapter 7

Objective:

Psychotherapy is designed to precipitate change in a patient's long-standing affective, cognitive, or behavioral functioning. The treatment may identify, when theory driven, maladaptive attitudes and beliefs that are present in an individual. A group leader should have a clear model of therapy and group development in mind as he/she facilitates the group process. The theoretical model (i.e. Interpersonal Theory, Cognitive-behavioral, Psychological rehabilitation) that structures group treatment will invariably differ across unit, patient population, and leadership style. A clear theoretical formulation of individual and group dynamics is what distinguishes this group types from more supportive (e.g. counseling) or educational (e.g. psycho-educational) groups. Moreover this treatment plan must, in turn, be calibrated not only with a patient's ICTP but also have support as being effective.

Definition:

Group psychotherapy focuses on both the content and the process of the discussion; what the group members say and how they say it. The dynamics of relationships formed in groups and how these are representative of group members' coping or avoidant styles are also monitored in psychotherapy. It is characterized by high levels of "cross-talk," self-disclosure, and psychological "risk-taking."

Developing a Group:

When a group leader begins psychotherapy group there are certain factors to consider. A group leader should:

1. Select and screen candidates appropriate to a group. The leader should have an ideal group composition that delineates the target population and individual member characteristics deemed important. The leader should evaluate a patient's suitability for a particular group by considering the patient's:

ICTP,
intellectual level,
cognitive organization,
willingness to participate.

2. Develop a treatment plan for a group. This group plan should clarify if the group will be

(a) time-limited, theme oriented, and structured or
(b) less structured, for a longer period of time, and tolerant to theme shifts.

Indeed the group plan will differ for the two types of groups. The structured group

plan will focus more on a lesson plan where the open-ended group will focus on expected development growth across time.

3. Clarify the specific leader characteristic and style (model) that will work most effectively with the group plan and target population. The leader should consider:

(a) Leader characteristics
(b) Pregroup training or supervision as needed
(c) Potential leadership difficulties
(d) Transference and counter-transference issues

4. Determine group leader competencies/skills for the particular group style. Examples may include:

(a) Group problem solving skill approaches
(b) Within crisis intervention approaches
(c) Recognition and intervention with self-defeating behaviors for group members
(d) Reasonable hypothesis about nonverbal behavior
(e) Criteria for appropriate feedback to and from members
(f) Individual change takes place in the development of the group
(g) Adjunct psychotherapy interventions such as homework

More information on specific skills/competencies will be available from your group coordinator.

Evaluate:

When a group ends it is essential to evaluate the group process and individual change among members. The evaluation of the efficacy of the group may prove to be difficult with process groups. Therefore a focus on the individual development may prove valuable. A group leader may also use empirical methods to evaluate a group, which are provided in the appendix of this manual.

Psychotherapy Group Plan

Group Theory: Interpersonal group therapy

Group composition/Patient Names:

Female adolescents (all ages): Kris Monica
Amanda Katie
Julie Veronica

Patient Indicator (diagnosis –bipolar, schizophrenia, depression; or life problem):

Going through adolescence and issues related with that life period.

Goals for patients (relate to ICTP):

1. Develop a positive self image

2. Communicate about personal issues/behaviors (anger, PTSD, eating disorders).

3. Discuss male/female relationships and appropriate behavior.

Leader training/competencies:

1. Interpersonal theory

2. Adolescent issues

Evaluation method:

Feedback from group members
Positives for each group member

Group Time/Date/Location:

Objective:

Psychoeducational groups can have one of three purposes: primary or secondary prevention, or remediation.

-Primary prevention groups are preemptive by nature serving as a medium to educate group participants who are presently unaffected about a potential threat (i.e. AIDA education), a developmental life event (i.e. parenthood, retirement) or how to cope with an immediate life crisis (i.e. loss of a loved one) with the goal of preventing an array of psychological disturbance from occurring.

-Secondary prevention groups are to prevent a relapse into a past behavior (i.e. relapse prevention).

-Remediation groups are to help patients acknowledge and change existing self-defeating behaviors (i.e. substance abuse).

Definition:

Psycho-educational groups focus on providing relevant information and skills to its members accompanied by interpersonal discussion in order to enhance group member's understanding, development and decision making. Such groups emphasize cognitive , affective, and behavioral development through a structured, sequenced set of procedures or exercises within and across sessions.

Developing a Group:

When a group leader begins to develop a psycho-educational group there are at least four factors to consider and assess. Specifically the group leader should:

1. Assess patient needs. Psycho-educational groups should be relevant to the patient to maintain the patient's interest and to provide quality treatment. The best place to document the patient's need is in their ICTP.

2. Determine the composition of the group. Composition considerations include patient level of functioning, patient status, gender, diagnosis, and age.

3. Develop a set of clear goals for the group. These goals should include:
   (a) the specific objective the group leader has for the group,
   (b) the knowledge or skills group members should acquire from the group
   (c) the individual goals for the group members.

4. Determine group leader competencies/skills that will be relied upon to conduct the group. Examples include:

(A) Develop a knowledge base relevant to the focus of the psycho-education group intervention. -- This will also serve as the basis for the format of the group. It will be an aid to the leader when questions or concerns arise from group members.

(B) Apply group development theory. While there are many theories that have been created, most are highly congruent. Incorporate a model that fits the specific content and objectives of the pyscho-educational groups. A good example of a developmental model was introduced by Trotzer. (Conyne, 158) The five individual stages include:

a. Security stage--Getting acquainted, setting boundaries, warm-ups
b. Acceptance stage --Personal sharing, feedback, resolving conflict
c. Responsibility stage--Self-assessment, ownership, responsibility
d. Work stage—Problem solving, mobilizing group resources
e. Closing stage—Giving support, confirming growth, follow-up

(C) Gain and apply group problem solving skills. These skills will be essential when dealing with difficult members (e.g psychotic, non participators, or aggressive). Your group coordinator will have reference materials to assist in these areas. Also these skills will serve as a model for group members to follow with their own personal problems.

(D) Create a sound group plan. The development of a group plan involves four steps:

a. develop a group blueprint (e.g, group theme, target population, major concepts and skills.
b. Sequencing major content areas with expected group development (relating major content and skills to a group development model).
c. Use phase specific group dynamic to build exercises and structures. (e.g delay risky exercises for later sessions)
d. develop session lesson plans for each.

Evaluate:

As a group ends it is essential to evaluate the group process and mastery of skills in group members. The evaluation of the efficacy of the group may prove to be difficult with prevention groups since the specific target has not yet happened. Therefore a focus on the attitudes toward the incident may prove valuable. In remediation groups consider evaluating change in attitudes and the symptoms associated with relapse. Group leaders may also strive to evaluate if additional support systems have developed among group members and the knowledge base that group members have developed during the course of the group.

Skills used in Psycho-Educational groups:

GROUP PROCESS: Group processes are critically important for all group work. Leaders need to be aware of human factors in group work and must be able to facilitate

positive dynamics. Attention to such processes as communication patterns, decision-making processes, seating arrangements, and interpersonal relations are critical. Because of the emphasis on teaching content or skills, psycho-education groups are especially susceptible to ignoring process. Group leaders may consider incorporating experiential learning cycles or behavioral skill training.

Experiential learning cycles include 5 steps:

1. experience a structured activity
2. share observations and reactions regarding structured activities
3. process events and dynamics
4. generalize what was learned
5. apply learning to specific situations outside of group

Behavior Skill training include:

1. modeling
2. shaping
3. coaching
4. guided rehearsal
5. generalization

A CAUTIONARY NOTE: Leaders can find themselves trapped in designing and delivering informational presentations related to the topic while minimizing attention given to group processes.

Psycho-educational Group Plan

Group Topic:

Group composition/Patient names:

Goal (what patients will accomplish by the end of group):

Session Format & objectives for each session:

Leader Role:

Group rules:

Evaluation method:

Psycho-educational Group Plan

Group Topic: Substance Abuse & Psychiatric Medications

Group composition/Patient names:

Pts who are in the Sunrise Day Treatment Program for Duel D4.

Goal (what patients will accomplish by the end of group):

1. At the end of this group, Pts will have a basic understanding of how drugs of abuse effect the brain.

2. At the end of this group, Pts will know the names, categories, possible side effects and what to do for side effects for each of their psychiatric meds.

Session Format & objectives for each session:

(See attached for session objectives).

Format

-Lecture and discussion-handouts used
-Question/Answers
-Pts share experiences and drugs of abuse.
-Response/reactions to psych. meds.

Leader Role:

-Facilitate lectures & discussions
-Encourage participation
-Verify understanding of material

Group rules:

1. Start on time, end on time, break times
2. Confidentiality
3. Respect others, listen
4. Participate by sharing experiences, Q & A.

Evaluation method:
Simple exam where Pt writes names of meds, why he/she takes them, and 2-3 side effects for each.

Objective:

A group activity that assists individuals to develop competence in basic living skills, maintenance of their living environment, compliance with their medication regiment, or development of social and interpersonal skills and appropriate behaviors.

Definitions:

These groups will vary in structure and topic. Attached is a list of topics that may be acceptable for a skills group. These topics are chosen to enhance a patient's treatment and daily living. There are a few types of skills groups including:

1. Recreation groups
2. Psychiatric Technician groups
3. Occupational Therapy groups

Each type will have a specific theory and structure.

Developing a Group:

When a group leader begins a skills group certain factors need to be considered. A group leader should:

1. Develop a clear objective of the group. A skills group is only effective if there are clear objectives or goals for each member. These goals may be selected from the list of topics that follows and needs to relate to the patient's ICTP.

2. Select and screen group members. Members of a skills groups should have a need or interest in the topic of the group. The group leader should consider if the group's objective is appropriate to the age, intellectual functioning, and gender of each group member.

3. Develop a group plan for the group. This should clarify the group format, session objectives, and group leader style.

4. Determine special needs of group. These needs can include:
   (a) Special location (e.g. kitchen for cooking)
   (b) Materials
   (c) Supervision

5. Determine leader skills/competencies for the particular group. Examples may include:
   (a) Maintain attention to the topic
   (b) Clarify goal for the group

(c) Develop and implement interventions to achieve group's objectives.
(d) Implement group decision-making methods
(e) Manage conflict in group

Evaluate:

For a group to be useful there needs to be some form of evaluation. The evaluation of a skills group may be the accomplishment of a goal or meeting objectives that were pre-determined. This may be examined on a group or individual level.

Skills Development Topics

Example:

1. Personal hygiene
2. Eating habits
3. Sleeping habits(adequate sleep).
4. Regular and adequate physical exercise.
5. Protecting self from harm(drugs, danger, noise, etc.).
6. Following a routine schedule(set by others).
7. Establishing a personal routine and schedule.
8. Regular setting own personal routine and schedule.
9. Basic safety rules.
10. Use of leisure/unstructured time.
11. Anticipating consequences of actions.
12. Basic rules (dorm, home, society).
13. Managing conflicts with authority figures.
14. Problem-solving skills.
15. Coping and stress management
16. Communication skills.
17. Building stable friendship patterns.
18. Labeling and expressing feelings appropriately.
19. Developing positive self-esteem.
20. Interpersonal skills.
21. Awareness of needs of others.
22. Extending self appropriately to others.
23. Effective decision-making skills.
24. Self-respect and worth.
25. Creative expression
26. New hobbies

SKILLS DEVELOPMENT GROUP CHECKLIST

Name of group Leader_____

Name of Group _____

Group Members _____
_____
_____

Assess needs of patients and select skills to be taught during group.

Skills to be taught _____
_____

Group Schedule
Time _____
Number of Weeks _____
Time of Group _____
Day of the week _____

___ 1st Session: Introduce group objectives and make group rules.

___ 2nd Session: _____

___ 3rd Session: _____

___ 4th Session: _____

___ 5th Session: _____

___ 6th Session: _____

___ 7th Session: _____

___ 8th Session: _____

___ 9th Session: _____

___ 10th Session: _____

SMT Approval _____

SKILLS DEVELOPMENT GROUP CHECKLIST

Name of group Leader ___Christine Christensen, P.T. _____

Name of Group _Cooking_____

Group Members _C.O., C.H., T.R., J.S., J.B., & A.T. _____
_____
_____

Assess needs of patients and select skills to be taught during group.

Skills to be taught _Math, following directions, working as a team, how to read a__ recipe._____
_____

Group Schedule

Time April 3rd, to June 15th
Number of Weeks ___10_____
Time of Group ___6-8pm___
Day of the week ___Monday__

___ 1st Session: Introduce group objectives and make group rules.

___ 2nd Session: __cupcakes_____

___ 3rd Session: __bread_____

___ 4th Session: __icing decorations___

___ 5th Session: __bread____

___ 6th Session: _ _pizza_____

___ 7th Session: __suckers_____

___ 8th Session: __different kinds of salad_____

___ 9th Session: ___tacos_____

___ 10th Session: __cookies___

SMT Approval _____

Objective:

Counseling groups focus on common problem of living in a less formal fashion. The goal is to manage stress and obstacles in day to day experiences to bring about behavioral change conducive to more effective daily functioning. These groups encourage members to resolve problems of living through interpersonal support and problem-solving and to assist one in handling future problems of a similar nature.

Definition:

Counseling groups focus on external causes of problems and the development of group and individual problem-solving competencies. The group place emphasis on affiliation and support for others. They can take on a large group focus (community meeting) or be based on a patient indication (substance abuse)

Developing a Group

When a group leader begins a counseling group there are certain factors to consider. A group leader should:

1. Define the group topic and a target population relevant to the group topic. The group topic should define the focus of the group and address relevant culture, gender, and developmental issues unique to that population. Other factors that a group leader should consider when screening for possible candidates include the patient's :

ICTP, needs, or problem list
intellectual level,
cognitive organization,
willingness to participate.

2. Develop a detailed plan for a group. This group plan should clarify

(a) leader characteristics important when working with this population
(b) necessary patient pre-group training and planning
(c) Difficulties within session and an action plan for resolution
(d) group composition

Determine group leader competencies/skills that will be used for the particular group style. These skills may include:

(a) Using and modeling group problem-solving approaches
(b) Effective intervention at critical incidents
(c) Work appropriately with disruptive members
(d) Use procedures to assist transfer and support changes
(e) Use adjunct structures such as homework

If a group leader is interested in more information on skills/competencies associated with counseling, please see your group coordinator.

Evaluate:

As a group ends it is essential to evaluate the group process and individual change among members. The evaluation of the efficacy of the group may prove to be difficult with process groups. Therefore a focus on the support system if any that developed among group members may prove valuable. A group leader may also use empirical methods to evaluate a group which are provided in the appendix of this manual.

Counseling Group Plan

Group Topic:

Group Composition/Patient Names:

Group Format (Eg.. Structured vs. Unstructured, Time-limited vs. Open ended):
Group leader role—facilitator, mediator, etc.

Session Format and Objectives (Eg.. duration):

Group Problem Solving Approaches (modality):

Adjunct structures (homework):

Evaluation method:

Group time/date/location:

Counseling Group Plan

Group Topic: Community Meeting

Group Composition/Patient Names:

All patients on the boy's side/All patients on the girl's side

Group Format (Eg.. Structured vs. Unstructured, Time-limited vs. Open ended): Group leader role—facilitator, mediator, etc.

Structured, open ended. The group leader primarily fills the role of facilitator.

Session Format and Objectives (Eg.. duration):
(See attached for format) The objectives are to provide a forum to dispense information. A place to recognize growth and advancement in the program. A forum to safely air general community concerns/issues from patient and staff perspectives. A forum to use problem solving skills in terms of finding appropriate solutions to individual and unit concerns.

Group Problem Solving Approaches (modality):

*Brain storming.

*Group solution based-anyone can offer solutions.

Adjunct structures (homework):

Committee assignments with specific agendas/personal assignments

Evaluation method:

Group time/date/location:

Diversional Activities

<u>Definition:</u>

These are activities provided by USH to entertain and engage the patients in an activity. They are not necessarily group treatment but are still crucial to a patient's complete treatment here. These activities promote social skills and

participation in a group setting.

Structure:

Diversional activities can be impromptu or well-planned. The schedule may differ due to the spontaneous nature of the activities. They may occur during group time on the unit to engage new patients who have not been placed in a group. These activities may take place on- or off- campus.

Skills & Competencies:

These groups do not require a lot of training in the leader. However the activities should be well supervised and documented. There should be permission granted by the appropriate supervisors, especially if traveling off-campus. Leaders should be trained to handle difficult situations and disruptive group members.

USH Professional Training Standards:

Trained staff working under the supervision of a licensed registered nurse.

Examples:

- Van Rides
- Sport activities
- Bingo
- Canteen
- Unstructured Crafts
- Unstructured Exercise
- Cooking
- Puzzles
- Games
- Music
- Community Events

Chapter 8

Frequently Asked Questions

This section is designed to address questions that arise during group treatment. These questions may be used as a reference to particular incidents that may occur during a group. If you have any suggestions or additions please inform your group coordinator so it will be included in the revisions. If additional support or materials are needed please contact your unit group coordinator. Please refer to the previous chapters for in depth information regarding these topics

How do I start a group?

Included in this manual is a chapter on running a group and on the specific type of group you choose to run. The group leader should review these standards to become familiar with group treatment at the hospital. Attend the group consult meeting to inquire about groups that are needed on the unit. Fill out the checklists included with each type of group. Present these checklists at the group consult meeting and receive leadership approval. Once your group is started continue attending group consult meetings.

How do I choose a group topic?

Group topics should be relevant to your unit's population. Each patient will have specific goals or areas that need to be addressed listed in their ICTP. Contact your AD and/or your groups coordinator to find out what patient needs are on your unit.

How do I get patients for my groups?

The group will dictate group composition. Select patients whose ICTP goals and functional characteristics match the goals of the group and invite patients to group after consulting with the SMT or leadership; inform them of their responsibilities and the objective of the group; determine their interest and willingness to participate in the group. The most important factor to consider when selecting group members is the patient's ability to function at the group's determined level. A grossly deviant member from a particular group type may produce a negative outcome.

INCLUSION CRITERIA

- Ability to perform group task
- Motivation to participate in treatment
- Problem areas compatible with goals of the group
- Commitment to attend group session and stay for the whole session

EXCLUSION CRITERIA

- Inability to tolerate group setting
- Tendency to assume deviant role
- Extreme agitation or psychosis

Noncompliance with group norms for acceptable behavior
Severe incompatibility with one or more of the members

How often do I need to hold a group?

Groups MUST be consistent to be effective. Please schedule your group on a day that will be the most conducive to consistency. Most groups should be held at a minimum of one time a week. If you cannot hold a group on the scheduled time or day please reschedule your group for another day that week to ensure the group is held once a week. If a group is canceled group members will begin to question the value of the group and may be demoralizing and draining for members.

How many patients should be in a group?

This will often depend upon the type of group. Most groups should have between 4-10 members to be most effective. Although this will be based on patient population (child, adult, geriatrics) and diagnosis a group of below 4 members lacks critical mass for effective interactions and will often stagnate. For example on the adolescent unit the group leader should consider integrating genders in the late adolescence but keep them separate during early adolescence.

Who can hold each type of group?

The USH has certain training standards that are necessary for each type of group. Please review these standards listed on each type of group definition.

Should I use a co-therapist?

USH recommends the use of co-therapist for core and target groups. This will help reduce cancellations due to leader absence since there are two leaders. Co-therapy is helpful for new group leaders to help support one another. The use of the male-female co-therapist offer a unique advantage to a group by offering and opening certain subjects to explore. However if the co-therapists are uncomfortable with each other and competitive then the group may fail.

What should my pregroup preparation include?

All members of a group should be informed about the time, location, procedure, and goals of the group. This is important and cannot be neglected, no matter how brief it is.

The purpose of this preparation

Explain principles of group treatment
Describe norms for appropriate behaviors
Establish contract about regular attendance
Raise expectations about helpfulness of group
Predict early problems and minimize their impact

What should I do if a patient is consistently absent to a group?

This problem may be demoralizing for members leading them to question the value of the group. It can waste time by summarizing past events for a patient who missed prior sessions. When absenteeism or tardiness occurs the group leader must respond immediately. A reminder that regular attendance is important for the group and a linking between group attendance and ICTP goals is useful. Later in group development irregular attendance may be addressed and processed by the group. In this inpatient setting membership turnover affects the cohesiveness of the setting. The therapist must adopt special techniques to minimize the disruptive effect by reframing the group to a single session.

What if a member wants to dropout or I want to remove a member?

A member dropping out or being removed from a group can be disruptive to group development. Unfortunately this can be common and the leader needs to act decisively. Some problems can be avoided with thorough pre-group preparation. Please remember that if the decision to remove a patient is made that proper documentation and justification should be recorded.

How do I effectively add new members?

The success of introducing new members largely depends on timing. A group can be reluctant to add new members if a group is in crisis or actively involved in a struggle. The new members needs preparation regarding the established group and the leader should reassure them that their participation will be at the patient's own pace. The new member should be engaged in the first meetings by an experienced group member or the leader.

How do I handle sub-grouping?

A subgroup often arises when a few members split off into smaller units. The therapist must be alert and ready to confront the problem when it occurs. Subgroup members may begin to feel loyalty to their subgroup will begin to keep secrets, grow inhibited to express thoughts or feelings. This situation can be either a high risk or high gain. The group leader should confront and explore within the confines of the group.

How do I handle conflict within a group?

Conflict is also a high-risk or high-gain group experiences. Conflict is signaled by the presence of negative interpersonal interactions that range from low key putdowns to outright ignoring of a member. Conflict can be used appropriately to create an affectively charged learning experience. Each group will have a level of tolerance for conflict and the leader needs to monitor the level that is appropriate for each individual group.

What should I do with difficult group member?

Often in group treatment certain members may be difficult. The following table is a brief introduction to these patients and interventions. If additional information is desired please refer to the references or group coordinator.

Type of Patient	Behaviors	Interventions	Group Outcomes
Monopolist initially	Talks endlessly; engulf time and attention for the group; assume role of jr. therapist or interrogator	Question the group why they allow one person to take all the time, work with the patient to encourage and support appropriate disclosures, ask for other opinions	Group is polite but may become frustrated and angry. Group will be to open up and
Silent reluctant sessions	Remains quiet withdrawn, and uninvolved in group process	Allow the patient to modulate participation but encourage the silent one periodically; comment on non verbal behavior, and encourage to reflect on others	If after 3 months the behavior does not improve provide concurrent individual and if the group becomes frustrated consider removal
Schizoid, obesessional, or overly rational emotion ignite	Emotionally block, isolate, and are interpersonally distant from others	The therapist should avoid attempts to ignite the patient, but encourages to differentiate the group or observe his somatic reactions to situations	Other members may become angry at the member's lack of and will attempt to emotion.

Help-rejecting Complainer bored as control	Solicits help and then rejects or sabotages help	Do not confues help asked for with help required, use therapeutic factors, help recognize their pattern and its effect on members	Initially memebers are solicitous and then and irritated. Faith in group process suffers members are under of the complaints

Borderline only	Fluctuating and unstable therapeutic alliance,	Reality test through feedback and observations, pursue	Group may tolerate 1-2 patients. Member may be frustrated
with	transference with leader. Distorts	concrete goals and positive feedback	the demands and regressive tendencies
of	interpersonal interactions	for good behaviors.	the patient
Acutely Psychotic	Experiencing delusions or	Intervene and encourage the group	May be supportive to established member,
to	hallucinations. May	to support member,	new members group
may	act in a manic fashion.	act decisively.	feel angry or guilty.

How could any elective group be considered PST?

PST is a standardized measure of the type and amount of treatment a patient at USH is receiving. It doesn't reflect every intervention, and shouldn't be stretched to include all therapeutic interactions. A liberal definition has been given to some diversional and educational leisure activities to allow leeway as to what groups count as PST, but such liberality may be abused if an attitude of number counting rather than patient treatment becomes the focus. Groups counted as PST are not necessarily included in the ICTP and don't always require a title, purpose statement, treatment objective, and action plan.

Some suggest that elective groups can be used as capstone groups utilizing skills learned in other groups and preparing patients for real-world experiences. Oftentimes, however, such elective groups lack structure and boast little therapeutic patient interaction. According to the definition of PST as "planned, scheduled treatment," some elective groups would not qualify. If any group is to be counted as PST, it should have a title, purpose, treatment objectives, and action plan. Without a purpose and scheduling, time cannot be counted as PST, even if it is therapeutic.

What is the role of the Group Coordinator?

1. Consultant in group programming with SMT
- identify weaknesses with competency and problem solve to find solutions
- review programming
- share staff interests
- recommend patients to groups (including initial patient assignments)
- recommend new groups

2. Run Group Consult
· Weekly meeting (minimum of 2 hrs/month; e.g., 30 min/week)
· Planned material highlighting basic group skills
· Implementer of Relationships between members, members and leader
· Facilitator of Treatment Factors
    - Creating a group structure conducive to a healthy system relationship
    - Creating and maintaining bonding among all group members
    - Bringing to the group an armamentarium of intervention possibilities
    - Applying said interventions in a flexible, variable manner
· Maintainer of Time Boundaries and Continuity
    - Ensure that group meeting occur at regular, schedules intervals
    - Provide continuity between session by recalling previous discussions
    - Periodic evaluation of goal setting
· Foster positive spirit
    - Belief and hope for improvement
    - Organizational, Personal, Unit

3. Accessing resources (not to CREATE resources, but to establish connections and methods to find them)

4. Attend semi-monthly Group Coordinator meetings to establish a hospital-wide network

5. Consult with the AD and/or Program Director to coordinate the daily unit program

How are patients assigned to groups?

WHAT: First, patient needs are identified and drive selection of groups offered. Consider needs patient identifies him/herself, as well as those identified by the referring agency (e.g., discharge goals, ICTP). Second, staff skills and interests determine which groups a unit can run; plan accordingly. Utilize a variety of open, closed, and slow open groups. Third, consider the group composition and clinical impact (functioning) of the patient within the group.

WHEN: Patients are regularly assigned to groups during a change of groups on a 6, 8, or 12-week schedule, and upon admission. New admits pose an extra challenge because patient functioning usually improves and stabilizes within a few weeks of treatment, necessitating new group assignments based on identified treatment needs. Rapid assignment to groups is critical, however, so assignment during or immediately following the intake interview is suggested.

WHO: Procedurally, group assignment takes place in clinical by the treatment team. Interim group assignments (e.g., before a clinical is held) may fall on the shoulders of a designated team member (e.g., social worker), but assignments should ultimately be approved by the team.

Chapter 9

Appendix

Hill Interaction Matrix

Curative Climax Index

Group Climate Questionnaire

Self Satisfaction Survey

Example of the Provo Papers: USH contributions

Group Resource Catalog (currently not available on Folio, see hard copy of manual)

1. Members point out how certain members have characteristic patterns of interaction OR members ask for or give reactions to specific behaviors of a member.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

2. Members express negative, critical or hostile feelings toward the group and its activities.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

3. Group leader attempts to stimulate interaction by probing and sponsoring members about reacting to or showing awareness of each other with members responding perfunctorily or not at all.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

4. Group leader gives impressions or reactions he has to other member.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

5. Members point out characteristic malfunctions or collaborative avoidances of certain topics or other inadequacies in the group process which prevent the group from serving the therapeutic needs of the members.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

6. members discuss certain non-personal topic areas that have significance for understanding their problems but with the focus remaining on the area under discussion.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

7. Members do not accept and are critical of a member's formulations or reports of his past out-group behavior or way-of-life, OR a member defends his past, out-group behavior or way-of-life.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

8. Group leader sponsors, probes or otherwise encourages members to reality test a certain member's formulation of his problem and to point out omissions and contradictions in member's presentation of his problem.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

9. Group leader sponsors, probes or otherwise encourages members to discuss how the group operates or might function.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

10. Members are reluctant to participate and do not contribute to the interaction.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

11. Members express negative or hostile feelings or delusional ideas about certain conditions, institutions or events.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

12. Group leader socialized informally with the group by talking about current events, gossip and other everyday subjects.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

13. Group leaser points out characteristic malfunctions or collaborative avoidances of certain topics or other inadequacies in the group process which prevent the group from serving the therapeutic needs of the members.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

14. Group leader attempts to stimulate interaction by probing and sponsoring members about the group with members responding perfunctorily or not at all.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

15. Members do not accept and are critical of a member's formulations or reports of his past or out-group behavior or way-of-life, OR a member defends his past, out-group behavior or way-of-life.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

16. Members socialize informally by good-natured give-and-take and joking, indulging in inside-jokes or offering pairing and support.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

17. Members socialize informally by talking about current events, gossip and other everyday subjects.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

18. Members discuss how the group operates or might function.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

19. Group leader attempts to stimulate interaction by probing and sponsoring members about themselves; their family, educational background, military experience, etc.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

20. Members give impressions or reactions they have to another member.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

21. Group leader socializes informally by talking about himself or other members in terms of family and educational background; military experience, etc.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

22. Group leader sponsors, probes or otherwise encourages members to discuss certain non-personal topic areas that have significance for understanding their problems with the focus remaining on the area under discussion.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

23. Group leader sponsors, probes or otherwise encourages members to indulge in ribbing, embarrassing, needling or verbally attacking others.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

24. Members express negative, critical or hostile feelings toward the group and its activities.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

25. Members point out in a topic discussion of non-personal matters, conclusions or insights derived from the discussion which have implications for the members' personal problems.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

26. Group leader indulges in ribbing, embarrassing, needling or verbally attacking others.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

27. Members socialize informally be talking about the group and its activities.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

28. Members socialize informally by discussing themselves; their family and educational background, military experience, etc.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

29. Group leader sponsors, probes or otherwise encourages members to express negative, critical or hostile feelings toward the group and its activities.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

30. Group leader attempts to stimulate interaction by probing and sponsoring members about discussing current events, gossip and other everyday subjects.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

31.Group leader discusses the manner in which the group operates or might function.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

32. Members express negative, or hostile feelings or delusional ideas about certain conditions, institutions or events.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

33. Members point out characteristic malfunctions or collaborative avoidances of certain topics or other inadequacies in the group process which prevent the group from serving the therapeutic needs of the members.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

34. Members give impressions or reactions they have to another member.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

35. Group leader socializes informally by good-natured give-and-take and joking, indulging in inside-jokes or offering pairing and support.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

36. Group leader points out in a topic discussion of non-personal matters, conclusions or insights derived from the discussion which have implications for the members personal problems.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

37. Group leader expresses negative or critical feelings about the group and its activities.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

38. Members point out in a topic discussion of non-personal matters, conclusions or insights derived from the discussion which have implications for the members personal problems.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

39. Group leader sponsors, probes or otherwise encourages members to be critical of a member's formulations or reports of his past, way-of-life or out-group behavior.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

40. Group leader sponsors, probes or otherwise encourages members to point out characteristic malfunctions or collaborative avoidances of certain topics or other inadequacies in the group process which prevent the group from serving the therapeutic needs of the members.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

41. Members explore aspects of a certain member's problem.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

42. Members indulge in ribbing, embarrassing, needling or verbally attacking others.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

43. members reality test a certain member's formulation of his problem by pointing out distortions, omissions or contradictions in member's presentation of his problem.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

44. Members discuss how the group operates or might function.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

45. Group leader sponsors, probes or otherwise encourages members to socialize informally by getting them to discuss themselves; their family and educational background, military experience, etc.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

46. Group leader points out how certain members have characteristic patterns of interaction, OR group leader asks for or gives reactions to specific behaviors of a member.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

47. Members socialize informally by good-natured give-and take and joking, indulging in inside-jokes or offering pairing and support.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

48. Group leader socializes informally by talking about the group.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

49. Group leader sponsors, probes or otherwise encourages members to explore aspects of a certain member's problem.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

50. The group is silent or uncommunicative.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

51. members point out how certain members have characteristic patterns of interacting, OR members ask for or give reactions to specific behaviors of a member.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

52. Group leader discusses non-personal topic areas that are relevant to problems of the group members.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

53. Members indulge in ribbing embarrassing, needling or verbally attacking others.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

54. Group leader sponsors, proves or otherwise encourages members to point out how certain members have characteristic patterns of interacting, OR to ask for or give reactions to specific behaviors of a member.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

55. Group leader sponsors, probes or otherwise encourages members to point out in a topic discussion of non-personal matters conclusions or insights they may have derived from the discussion which have implications for the member's personal problems.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

56. Members are reluctant to participate and do not contribute to the interaction.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

57. Group leader is critical of a member's formulation or report of his past, out-group behavior or way-of-life, OR the group leader defends his past, out-group behavior, or way-of-life.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

58. Members reality test a certain member's formulation of his problem by pointing out distortions, omissions or contractions in member's presentation or his problem.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

59. Group leader explores aspects of a certain member's problem.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

60. Members socialize informally by discussing themselves; their family and educational background, military experience, etc.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

61. Members socialize informally by talking about current events, gossip and other everyday subjects.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

62. Group leader expresses negative or hostile feelings about certain conditions, institutions or events.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

63. Group leader sponsors, probes or otherwise encourages members to socialize informally by getting them to talk about the group and its activities.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

64. Leader participates and contributes to the group interaction.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

65. Group leader sponsors, probes or otherwise encourages members to socialize informally by getting them to indulge in good-natured give-and-take, joking and inside-jokes, or offering support and pairing.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

66. Group leader sponsors, probes or otherwise encourages members to socialize informally by getting them to talk about current events, gossip and other everyday subjects.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

67. Members socialize informally by talking about the group and its activities.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

68. members explore aspects of a certain member's problem.

0	1	2	3	4	5	6
No Members	One Member	Two Members	Three Members	Four /Five Members	Five/Six Members	Eight or more Members

69. Group leader sponsors, probes or otherwise encourages members to express negative feelings or delusional ideas about certain conditions, institutions or everyday events.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

70. Group leader reality tests a member's formulation of his problem by pointing out distortions, omissions and contradictions in member's presentation of problem.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

71. Members discuss certain non-personal topic areas that have significance for understanding their problems but with the focus remaining on the area under discussion.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

72. Group leader sponsors, probes or otherwise encourages members to give impressions or reactions they have to another member.

0	1	2	3	4	5	6
Not at all	0-1% of time	1-5% of time	5-10% of time	10-20% of time	20-40% of time	40-100% of time

CCI

Following are 14 statements that describe various aspects of participating in a group. Each of the 14 aspects may or may not have been helpful for you during your total experience in this group.

Please indicate how helpful you think each aspect has been for you in this group by reading each statement carefully and then circling one out of the five numbers.

Remember to base your answers on your total experience in this group and not just your most recent session.

Please circle only one number for each statement. Also, please do not omit an answer to any statement. Each statement is important, so try to anwer each one as honestly as possible.

RATING SCALE
1 = not helpful
2 = slightly helpful
3 = moderately helpful
4 = definately helpful
5 = extremely helpful

1. Being able to say what was bothering me instead of holding it in. 1 2 3 4 5
2. Belonging to and being valued by a group. 1 2 3 4 5
3. Feeling less alone and more included in a group. 1 2 3 4 5
4. Learning that I react to some people or situations unrealistically with feelings that somehow belong to earlier periods of my life. 1 2 3 4 5
5. Learning how to express my feelings. 1 2 3 4 5
6. Continued close contact with other people. 1 2 3 4 5
7. Learning how I block off my feelings towards others in the present. 1 2 3 4 5
8. Belonging to a group of people who understood and accepted me. 1 2 3 4 5
9. Expressing negative or positive feelings toward other persons in the group. 1 2 3 4 5
10. Discovering and accepting previously unknown or unacceptable parts of myself. 1 2 3 4 5
11. Expressing my feelings even though I am uncertain. 1 2 3 4 5

4 5

12. Belonging to a group I liked. 1 2 3 4 5

13. Learning why I think and fell the way I do (i.e., learning some of the causes and sources of my problems). 1 2 3 4 5

14. Learning how to share, in an honest and responsible way, how group memvers come across to me. 1 2 3 4 5

GCQ

Name:_____Date:_____ Group:_____

* Read each statement carefully and try to think of the whole group.
* Using the Rating Scale as a guide, circle the number that best describes the group during today's meeting.
* Please mark only ONE answer for each statement.

Rating Scale

0 not at all
1 a little bit
2 somewhat
3 moderately
4 quite a bit
5 a great deal
6 extremely

1. The members liked and cared about each other. 0 1 2 3 4 5 6
2. The members tried to understand why they do the things they do, tried to reason it out. 0 1 2 3 4 5 6
3. The members avoided looking at important issues going on between themselves. 0 1 2 3 4 5 6
4. The members felt what was happening was important and there was a sense of participation. 0 1 2 3 4 5 6
5. The members depended on the group leader(s) for direction. 0 1 2 3 4 5 6
6. There was friction and anger between the members. 0 1 2 3 4 5 6
7. The members were distant and withdrawn from each other. 0 1 2 3 4 5 6
8. The members challenged and confronted each other in their efforts to sort things out. 0 1 2 3 4 5 6
9. The members appeared to do things the way they thought would be acceptable to the group. 0 1 2 3 4 5 6
10. The members rejected and distrusted each other. 0 1 2 3 4 5 6
11. The members revealed sensitive personal information or feelings. 0 1 2 3 4 5 6

12. The members appeared tense and anxious. 0 1 2 3 4 5 6

SSS

Name:_____ Today's Date:_____

Group:_____

Read each statement carefully. Notice that some are positive, others are negative. There are **no** right or wrong answers, so please be honest. Answer each item carefully and as accurately as you can by placing a number beside each one as follows:

1=Strongly disagree
2=Disagree
3=Uncertain
4=Agree
5=Strongly Agree

_____I have been able to express my feelings in the group.

_____I am discouraged about group counseling at this point.

_____I have made some progress in achieving my goals.

_____I believe the group counselor can help us work together.

_____I don't feel the group understands me.

_____The group has not worked together well.

_____I have found the group counseling sessions to be helpful.

_____I feel like quitting the group.

_____I have been able to talk about my concerns in the group.

_____I don't feel the group will be able to help me.

USH Contributions to Provo Papers

Provo Papers

Vol. I, No. I, January 1957

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Forward

"The old order changeth, yielding place to new,..." Social systems and institutions are in a highly fluid, transistional state. Each change brings nascent conditions which lend themselves most favorably to new perspectives and new procedures.

State Hospitals are in the midst of this complex "reactor." The products that will emerge may not be wholly foretold, but that some will be new and unexpected is certain. The appearanve of Provo Papers is a commentary on and a verification of this fact.

This new publication has the potential of not only distributing information, but of recording the titler of scientific thought as it pertains fo the State Hospital and what is even more important, of acting as a catalyst for the same.

To one who is aquainted with the old-time State Hospital, this transformation brings a distinct pleasure. I am confident Provo Papers will contribute measureably to high professional standards and to the quality of services available.

Owne P. Heninger, M. D.

Editorial

Inconsidering possible names for out new journal, the tital "Provo Papers" was chosed as being less presumptuous and though alliterative, more appropriate than some other suggested titles. Our purpose is to develop a more casual format and more accessible forum than in the presently established professional hournals in the mental health specialties. We hope the name, Provo Papers, communicates thus purpose and we will not be surprised if it also conjures up association with other distinguished publications. If the association that comes to mind is Pickwick Papers, let it be bourne in mind that the Pickwick Club was founded, so Dickens says, to further the cause of science and the diffusion of learning, certainly a goal not inconsistent with this journal. Another association might well be the Pogo Papers, and we make no claim that our journal will produce insights into human behavior as incisice as those produced by the cartoonist, Walt Kelly. Rather, our aspiration is that the name of our Journal will be associated with something akin to the Elgin Papers, a distinguished journal published by the Elgin State Hospital in Illinois.

Provo Papers are linked intentionally with a state hospital- Utah State Hospital. It is worth observing that on both the local and the national scene there is a tremendous development of interest and concern in upgrading state hospitals. The appearance of a state hospital publication at this time is indeed propitous and is more than coincidental.

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